The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Board of Registration in Nursing
www.mass.gov/dph/boards/rn

ATTESTATION FOR REGISTER NURSE LICENSURE APPLICANTS WHO COMPLETED A CLOSED NURSING EDUCATION PROGRAMS OR NURSING EDUCATION PROGRAM THAT IS UNABLE TO CONFIRM DIRECT PATIENT CLINICAL EXPERIENCES REQUIREMENTS TO ATTEST TO YEARS OF NURSING PRACTICE

To be completed by applicants who completed closed nursing education programs or a nursing education program that is unable to confirm direct patient clinical experience requirement in adult medical-surgical, pediatric, obstetrics, and/or mental health with clinical substitution as defined by the National Counsil of State Boards of Nursing (NCSBN) guidelines, during the time of attendance, due to length of time since program completion for applicants who are applying for initial licensure by examination and reciprocity licensure in Massachusetts

***NCSBN Guidelines: Direct patient care clinical experience with substitution of no more than 50% for each course.**

Traditional Clinical Experience: Practice in an inpatient, ambulatory care or community setting where the student provides care to patients under the guidance of an instructor or preceptor.(NCSBN, 2016)

I _____

(**Applicant's**) (**First**) **(Middle)** **(Last)** **(Year of Birth)**

A graduate from _____

(Nursing Education Program Name)

Located _____

(Address) **(City/Town)** **(State, Zip/Postal Code)**

(Type of degree or certificate awarded)

Program Type ☐RN DIPLOMA ☐RN ASSOCIATE
Check one * ☐RN BACCALAUREATE ☐RN ENTRY-LEVEL ☐RN ENTRY LEVEL
☐RN OTHER _____ MASTERS DOCTORATE

*Date of Graduation** _____ _____
(MM/DD/YYYY)

Hereby submit to having two (2) years or more of full-time nursing practice experience or its equivalent within the past five (5) years.

Attestation: By signing this Affidavit, I certify, under the pains and penalties of perjury, that the information provided herein is truthful and accurate.

Name (print):_____ Title: _____

Signature:_____ Date:_____

Submit this form directly to PCS at:
Professional Credential Services
ATN: MA Board of Registration in Nursing
C/O MA Nurse Coordinator
P.O. Box 198788, Nashville, TN 37219